Aging and Physical Disabilities
Module
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COMPETENCIES FOR AGING AND PHYSICAL DISABILITIES MODULE

1. Restate and apply the principles of caregiving pertaining to older adults and persons with physical disabilities. (I)
2. Describe and explain the roles, responsibilities, requirements, and scope of practice for Direct Care Workers (DCWs). (I)
3. Describe and explain legal and ethical issues related to vulnerable adults, guidelines for avoiding legal action, and methods for protecting consumer rights. (I)
4. Describe the development and importance of following service/care plans. (I)
5. Identify and describe the end-of-life issues as they relate to responding to the changing care needs. (I)
6. Identify and describe biological changes as they relate to the aging process and implications for caregiving. (II)
7. Identify and describe the major chronic conditions, physical disabilities, and sexuality issues of consumers, and the therapeutic interventions used. (III, V, VI)
8. Describe common psychological and cognitive conditions of consumers, behavioral, communication, and safety issues associated with these conditions, and effective techniques for addressing them. (IV)
9. Identify and describe dementia-specific care related to the types and stages of dementia, communication and safety issues, managing difficult behaviors, pain management techniques, and importance of activities. (VII)
10. Identify and describe the activities of daily living issues related to dementia-specific care. (VII)
11. Demonstrate selected personal care skills as they relate to dementia-specific care. (VII)

AGING AND PHYSICAL DISABILITIES MODULE

SECTION I - Overview

Review Sections I - III and V from the Principles of Caregiving Core

AGING AND PHYSICAL DISABILITIES MODULE

SECTION II - BIOLOGICAL ASPECTS OF AGING

Biological Aspects of Aging (Refer to chart on the next page)

A. Heart and lungs

1. Biological changes

a. Heart does not pump as efficiently (pump begins to “poop out”)
b. Lungs do not exchange oxygen and carbon dioxide as efficiently
c. Not as much oxygen delivered to all parts of the body
d. Decreased blood flow to all parts of the body

2. Implications for care

a. Rest before changing positions to prevent fainting
b. Allow more time (don’t rush) for ADLs including walking, bathing, dressing

B. Kidneys and bladder

1. Biological changes

a. Decreased function of the kidneys - not as able to filter medication by-products
b. Decreased bladder capacity (2 cups at age 25; 1 cup as an elder)
c. Decreased signal time for urge to urinate; may urinate as urge signal received leading to incontinence
d. Increased incidence of stress incontinence and urinary retention (increased bladder/kidney infections)
e. Prostate gland increases in size

2. Implications for care

a. Monitor for toxic medication reactions
b. Prevent incontinence with routine toileting every two hours, use easy to remove clothing, and use a bedside commode as indicated
c. Monitor for signs of bladder/kidney infections (change in behavior, increased temp, change in odor/color of urine, burning/painful urination etc.)
d. Monitor for signs of skin breakdown

Changes As We Age And Implications For Care

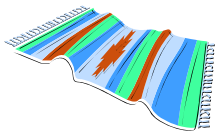
	Physical Change with Aging	Implications for Care
Heart and Lungs	• ↓ Cardiac and lung function • ↓Blood flow • Not as much oxygen delivered to all parts of the body	• Allow more time for ADL's including walking, bathing, dressing • Rest before changing positions to prevent fainting
Kidneys, Bladder	• ↓ Function of kidneys➔ medication toxicity • ↓ Bladder capacity: 2 C @25; 1 C elder • ↓ Signal time for urge to urinate; may urinate as urge signal received causing incontinence • ↑ Incidence of stress incontinence & urinary retention ➔ bladder/kidney infections • ↑ Size of prostate gland in men➔ BPH	• Be aware of medication side effects • Prevent incontinence; regular toileting, easy to remove clothing, use bedside commode • Watch for sign of bladder/kidney infections (change in behavior, low grade fever, frequent/painful urination) • Watch for signs of skin breakdown
Muscles, Bones, Tendons and Ligaments	• Loss of muscle tone; joints less flexible • Osteoporosis-bones less dense, more brittle with increased risk of fractures • Cartilage between vertebra shrinks ➔shorter, stooped posture • Slower reflexes and coordination➔ falls	• Prevent falls by clearing pathways and removing scatter rugs • Avoid rushing elder when walking • Encourage use of hand rails and/or assistive devices for support
Nervous and Immune System	• Sleep pattern changes, ↑ wakening • Nerves react more slowly; less sensitive to pain and temperature extremes, • ↓ Sensitivity to pain; injuries may go undetected • ↓ Ability to fight infections	• Encourage quiet mental stimulation or light snack during wakeful periods at night • Check skin, especially feet for cuts, bruises, burns • Watch for signs of infection: fever, ↓ appetite, poor color, change in behavior
Brain, Intelligence, and Memory	• Loss of brain cells, learning takes longer • Takes longer for brain to search and retrieve • Intellect, judgment, comprehension, and retention usually do not change with age	• Reduce stress of learning new things, keep environment calm and routine • Present new things visually and verbally • Notify Supervisor of sudden change in memory
Vision	• ↓ Visual acuity, difficult to read and judge distance • ↑ Sensitivity to glare • Changes in lens of the eye (cataracts) • ↑ Risk of glaucoma	• Provide adequate lighting day and night • Reduce glare (mirrors, high gloss furniture, etc.) • Use contrasting colors for floors, walls, steps • Use eyeglasses and keep them clean • Arrange for annual eye exams
Hearing	• ↓ Hearing; high frequency sounds distorted; difficult to hear if they can not see speaker or person has background noise • May withdraw or get depressed • Earwax buildup easily overlooked	• Speak clearly but don't shout • Face person, remove anything from mouth (gum, food) • Encourage use of hearing aids; clean w/ soft brush; have good batteries available • Have Health Care Provider examine ears
Digestion, Taste, Smell, Mouth and Teeth	• ↓ Gastric acid and saliva enzyme production • Slowed colon action can lead to indigestion, constipation • Loss of teeth; person doesn't chew food as well • ↓ Sense of taste & smell, food may not taste the same leading to poor appetite and malnutrition	• Avoid foods that are difficult to digest or chew • For constipation: ↑ fluid intake, fresh fruit, veggies, whole grains, prunes, exercise • Add appropriate herbs, spices, and have pleasant eating environment • Important to keep record of person's weight, appetite, and bowel regularity
Skin, Hair and Fingernails	• Skin is drier, less elastic, more fragile; bruises and tears more easily • Fatty layer decreases (↓ natural padding) • ↑ Facial hair in women (may need trimming) • Nails thicken and become more brittle	• Use lanolin based soaps; ↓ use of antibacterial or deodorant soaps or alcohol based products • Watch for signs of skin breakdown • Change position at least every two hours • File nails, Do Not Clip

C. Muscles, bones, tendons, and ligaments

1. Biological changes

a. Loss of muscle tone; joints become less flexible
b. Bones become more porous, more brittle with increased risk of fractures
c. Cartilage between vertebrae shrinks making the person shorter with stooped posture
d. Slower reflexes and coordination increases risks for falls

2. Implications for care



a. Prevent falls by removing barriers and scatter rugs and clearing pathways
b. Avoid rushing the elderly person when walking
c. Encourage use of hand rails and/or assistive devices for support
d. Ensure adequate lighting especially at night

D. Nervous and immune system

1. Biological changes

a. Sleep pattern changes, increased waking during the night
b. Nerves react more slowly; less sensitive to pain and temperature extremes
c. Decreased sensitivity to pain; injuries may go undetected
d. Decreased ability to fight infections

2. Implications for care

a. Encourage quiet mental stimulation or light snack during wakeful periods at night
b. Check skin for any signs of breakdown
c. Check feet and between toes for cuts, bruises, burns or lesions
d. Watch for signs of infection: **change in behavior**, fever, decreased appetite, poor color

E. Brain, intelligence, and memory

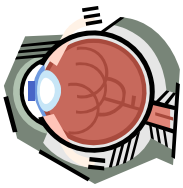
1. Biological changes

a. Loss of brain cells, learning takes longer
b. Takes longer for brain to “search and retrieve”
c. Intellect, judgment, comprehension, retention usually do not change with age

2. Implications for care

a. Reduce stress of learning new things, keep environment calm and routine
b. Present new things visually and verbally
c. Notify Supervisor if consumer has sudden change in memory

F. Vision



1. Biological changes

a. Decreased visual acuity, difficult to read and judge distance
b. Increased sensitivity to glare
c. Changes in lens of the eye (cataracts)
d. Risk of increasing fluid pressure within the eye (glaucoma)

2. Implications for care

a. Provide adequate lighting day and night
b. Reduce glare (mirrors, high gloss furniture, etc.)
c. Use contrasting colors for floors, walls, steps
d. Use eyeglasses and keep them clean
e. Arrange for annual eye exams

G. Hearing

1. Biological changes

a. Decreased hearing acuity
   - High frequency sounds distorted
   - Difficult to hear if person cannot see speaker
   - May withdraw or get depressed due to not being able to join in conversations
b. Increased earwax buildup can easily be overlooked

Discuss use of personal amplifier as alternative to hearing aids

2. Implications for care

a. Speak clearly but don't shout; reduce background noise (turn off TV and radio, etc.)
b. Face person when talking, remove anything from mouth (gum, food)
c. Encourage use of hearing aids (clean aids with soft brush; have extra batteries)
d. Have health care provider examine person's ears

H. Digestion, taste, smell, mouth, and teeth

1. Biological changes

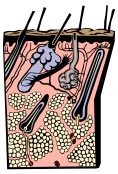
a. Decreased gastric acid and saliva enzyme production
b. Slowed colon action can lead to indigestion and constipation
c. Loss of teeth; affects being able to chew food
d. Decreased sense of taste and smell; food may not taste the same

2. Implications for care

a. Avoid foods that are difficult to digest or chew
b. For constipation: increase fluid intake, fresh fruit, veggies, whole grains, prunes, and exercise
c. To encourage intake add appropriate seasonings and have pleasant eating environment
d. Important to keep record of person's weight, appetite, and bowel regularity

I. Skin, Hair and Fingernails

1. Biological changes



a. Skin is drier, less elastic, more fragile; bruises and tears more easily
b. Fatty layer decreases (decreased natural padding)
c. Increased facial hair in women (may need trimming)
d. Nails thicken and become more brittle

2. Implications for care

a. **GOAL IS TO KEEP SKIN INTACT**
b. Use lanolin based soaps instead of antibacterial or deodorant soaps or alcohol-based products
c. Inspect the person's skin for signs of skin breakdown frequently
d. Use lotion to help keep the person's skin supple and relieve dry, scaly skin
e. **Change the person's position in bed or chair at least every two hours to relieve pressure**
f. File nails, **Do Not Clip**

A Tip: To relieve extreme dryness of the hands and/or feet apply petroleum jelly to the area and cover with cotton gloves or socks before going to bed.

Refer to other skin care strategies and information on pressure ulcers found in the personal care section of the Core Training

AGING AND PHYSICAL DISABILITIES MODULE

SECTION III - ACUTE AND CHRONIC CONDITIONS

A. Therapeutic interventions

Therapeutic interventions are care strategies and treatments given based on individual diagnosis and needs and addressed in the care/support plan.

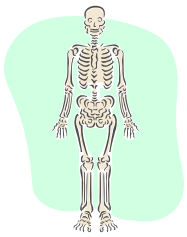
B. Acute versus chronic illnesses

1. Differences

a. Acute illnesses progress rapidly, last a certain length of time, and then the person recovers.
b. Chronic illnesses are long-term conditions requiring prolonged care. According to the U.S. National Center for Health Statistics a chronic illness lasts three months or more.

2. Joints and bones

a. Arthritis—Causes inflammation and deterioration of the joints. There are two main types:



- Osteoarthritis
  - ✓ Degeneration of the joints causing pain and stiffness
  - ✓ Most common form of arthritis—90% of people over 50 have some osteoarthritis
  - ✓ Symptomatic treatment is aspirin or non-steroidal anti-inflammatory drugs (e.g., Ibuprofen, Naproxen)

- Rheumatoid Arthritis (RA)
  - ✓ More severe form but less common
  - ✓ Causes joint deformities
  - ✓ More difficult to treat since it is considered an auto-immune disease (immune system turns against itself)
  - ✓ Can also affect internal organs such as heart, lungs, and muscles

Note: Non-verbal elders with certain conditions (e.g., dementia) may have problem behaviors due to unrelieved arthritis pain

b. Osteoporosis--Loss of calcium in the bones making them porous and brittle causing increased risk of fractures

- Risk factors- hereditary factors, decreased calcium intake, lack of exercise
- Treatments aimed at meds to increase calcium uptake and weight training (exercising with weights helps calcium re-absorption)
- Causes shortened stature as the vertebrae collapse and the spine curves leading to decreased range of motion and painful mobility
- Causes compression fractures of the spine
- Fractures increase risk of joint replacement surgery
  - ✓ Major surgery can cause complications in elderly persons
  - ✓ Majority of elders who have hip replacement surgery never return to prior level of functioning

3. Heart

a. High blood pressure/hypertension (HBP, HTN)

High blood pressure affects almost 30% of adults in the U.S., yet most of these people have no symptoms. Uncontrolled high blood pressure can lead to stroke, heart attack, heart failure or kidney failure. The only way to tell if a person's blood pressure is within the normal range is to have it checked regularly.

Blood pressure guidelines are:

The target BP should be	Less Than 140/90
If the person has diabetes or kidney problems the target BP should be	Less than 130/80
When to notify the Health Care Provider	
Systolic (top number)	Less than 90 Greater than 160
Diastolic (bottom number)	Less than 60 Greater than 90

b. Cardiovascular disease--involves the heart and/or blood vessels (arteries and veins)

This disease usually refers to plaque formation on the internal walls of the vessels, namely the coronary arteries. The plaques (atherosclerosis) can totally obstruct the passage of blood causing pain (angina) and death of the affected heart muscle (myocardial infarction).

c. Angina

Angina is chest pain due to the lack of blood (oxygen supply) to the heart muscle generally due to obstruction of the coronary arteries. Some individuals have known blockages but are not good surgical candidates for coronary artery bypass surgery. Therefore, medications to dilate blood vessels are prescribed.

Nitroglycerin (NTG) is such a drug. When the person feels chest pain (can also be pain radiating down arm or jaw) he/she should rest, and take NTG if prescribed. Usual prescription dosing is one NTG pill under the tongue and wait 5 minutes. If the pain persists, the person can repeat the sequence up to two more times.

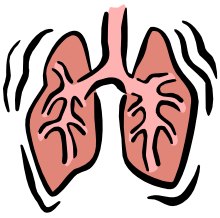
Note: If you assist someone in taking a NTG pill, always put the pill in the bottle cap, not in the palm of your hand, as the pill can dissolve in the sweat on your hand giving you the side effects of the med (severe, pounding headache). Also, the person needs to get a fresh supply of NTG tablets every six months as the pills are destroyed by light.

d. Heart attack (myocardial infarction, "MI")

The heart muscle that does not get the needed blood (oxygen) dies. The extent of the affected muscle determines the functional impairment the individual will have following the heart attack. Cardiac rehabilitation, aimed at progressive exercise, will help the person regain strength and learn how to avoid future attacks through proper diet and exercise.

4. **Lungs—Chronic Obstructive Pulmonary Disease (COPD)**
   Includes chronic bronchitis, asthma, and emphysema

   a. Emphysema



- Breathing is difficult due to swollen, inflamed air passages, damaged air sacs (alveoli) in the lungs, excess mucous, and anxiety
- Treatment includes medications, quitting smoking, staying as active as possible, and oxygen therapy
  - ✓ Oxygen precautions include:
    - Keep tubing away from any heat source including cigarettes and space heaters
    - Store E-tanks upright but secure so they cannot be bumped into or fall over
    - When traveling make sure the E-tanks are secured in the car **(use a bungee cord and strap the tank to the back of the passenger seat)**

   b. Asthma

   The individual is hyper-sensitive to certain things such as allergies, viral infections, cold air, exercise, smoke, etc. When exposed to one of these (a flare-up or exacerbation) the person's air passages become swollen and restrict air movement. Immediate medical attention/medications (including the use of inhalers) is indicated or the condition could lead to respiratory arrest and even death.

5. **Brain and nervous system**

   a. **Stroke (Cerebrovascular Accident—CVA)**

   Brain damage occurs when blood flow to or within the brain is interrupted. Without the oxygen in the blood the brain cells die. The location of those damaged cells will determine the symptoms and severity of the stroke.

   Signs and symptoms of a stroke include drooping of one side of the face, slurred speech, visual disturbances, uncoordination or paralysis of extremities.

   There are two types of strokes:

- Hemorrhagic:
  When a blood vessel breaks and leaks blood into the surrounding tissue. Can be caused by a weakened artery wall (aneurysm) or by trauma
- Ischemic:
  Interruption of blood flow due to a clot or plaque formation

   If the cause is ischemic a medication can be given within the first three hours (per American Heart Association guidelines) that will greatly reduce the effects of the stroke. If the cause is hemorrhagic the same medication can cause further bleeding

and possibly death. **Therefore, it is imperative the individual be evaluated in the emergency room for the appropriate treatment within two hours of onset of symptoms.**

Possible effects of a stroke:

Paralysis	Depression
Memory loss	Emotional instability
Impaired judgment	Seizures
Aphasia (difficulty expressing oneself)	

It is also imperative following a stroke that the individual get rehabilitative therapy **as soon as possible** to decrease impairment and learn how to manage ADLs with the impairment.

The caregiver can also help by allowing the person to be as independent as possible and to allow plenty of time for independent function. This will help decrease depression.

b. **Parkinson's disease**

- Caused by a chemical imbalance (decreased dopamine) in the brain causing rigidity in movements (freezing), tremors, loss of balance and coordination, and loss of facial movements (blank affect)
- The individual may have problems chewing, swallowing, or speaking
- Can lead to dementia
- Do not mistake blank affect for lack of comprehension

c. **Dementia** (Covered later in the Dementia-Specific Care section)

d. **Vision impairment**

- Cataracts
  - ✓ Cloudiness of the lens of the eye leading to decreased night vision, glare, and blurry vision
  - ✓ Current treatment includes out-patient laser surgery
  - ✓ Post-op care includes multiple eye meds and restrictions on lifting and bending over

- Glaucoma
  - ✓ Fluid pressure builds up inside the eyeball causing pressure on the optic nerve leading to blindness. Damage is irreversible
  - ✓ Usually the person does not feel any pressure so it can only be diagnosed with an eye exam
  - ✓ Treatment includes eye drops and sometimes surgery
  - ✓ Annual eye exams over age 40 are important

- Macular degeneration

  - ✓ Leading cause of blindness in people over 50
  - ✓ The macula (an area of the retina) begins to deteriorate causing blurry or spotty central vision
  - ✓ Vitamins with minerals may help
  - ✓ Low vision aids such as well-lit rooms (but reduce glare), using high contrasting colors, and use of large print books will help

6. Diabetes

Diabetes is an imbalance in glucose and insulin in the blood. Insulin is produced by the pancreas and is responsible for transporting glucose molecules in the blood into the cells. **Normal range for fasting blood glucose is 90 to 110**. There are two main types of diabetes:

a. **Type I (Early onset/Insulin dependent)**

- Pancreas no longer produces insulin (possibly an auto immune disorder)
- Individual must have insulin injections

b. **Type II (Late onset/Diet controlled)**

- Due to:
  - ✓ Deficiency in insulin production (not enough to meet needs)
  - ✓ Cells become resistant to insulin
- Previously it was seen as only affecting older adults. Now being seen in children
- Possible causes: heredity and diet high in fat and sugar

c. **Treatment:**

- Diet—can also control "borderline diabetes" (blood sugars just slightly elevated)- currently, diet focuses more on amount of carbohydrates consumed at each meal rather than limiting concentrated sweets (allows more food choices)
- Exercise—exercise reduces blood glucose so diabetics are encouraged to be as active as possible
- Oral medications aimed at increasing insulin production or decreasing the cell's resistance to insulin
- Insulin – by injection at least once per day -- there are different types and lengths of action — now available in powder form that is inhaled

d. **Diabetic complications** (control blood sugars to decrease risk)

- Blindness
- Damages lining of vessels and arteries increasing risk for heart attacks, strokes, and amputations
- Wounds, skin lesions, incisions, etc. heal slowly
- Kidney damage and failure
- Nerve damage in extremities (diabetic neuropathy)
- Impotency in men; high risk pregnancies

CHANGINGlife WITHDIABETES

Hypoglycemia (Low Blood Glucose)

Causes: Too little food or skipping a meal; too much insulin or diabetes pills; more active than usual.

Onset: Often sudden.

Some Symptoms:


SHAKY


FAST HEARTBEAT


SWEATING

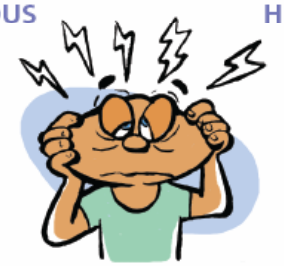

DIZZY


ANXIOUS


HUNGRY


BLURRY VISION


WEAKNESS OR FATIGUE


HEADACHE


IRRITABLE

IF LOW BLOOD GLUCOSE IS LEFT UNTREATED, YOU MAY PASS OUT AND NEED MEDICAL HELP.

What Can You Do?

CHECK your blood glucose, right away. If you can't check, treat anyway.

TREAT by eating 3 to 4 glucose tablets or 3 to 5 hard candies you can chew quickly (such as peppermints), or by drinking 4-ounces of fruit juice, or 1/2 can of regular soda pop.

CHECK your blood glucose again after 15 minutes. If it is still low, treat again. If symptoms don't stop, call your healthcare provider.

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

Concept developed by Rhonda Rogers, RN, BSN, CDE

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Note: These are also the symptoms for undiagnosed diabetes

CHANGINGlife WITHDIABETES

Hyperglycemia (High Blood Glucose)

Causes: Too much food, too little insulin or diabetes pills, illness, or stress.

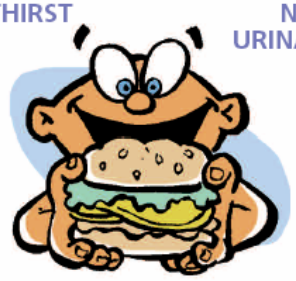
Onset: Often starts slowly.

Some Symptoms:

EXTREME THIRST

NEED TO URINATE OFTEN

DRY SKIN



HUNGRY

BLURRY VISION

DROWSY

SLOW HEALING WOUNDS

HIGH BLOOD GLUCOSE MAY LEAD TO A MEDICAL EMERGENCY IF NOT TREATED.

What Can You Do?

CHECK BLOOD GLUCOSE

If your blood glucose levels are higher than your goal for three days and you don't know why,

CALL YOUR HEALTHCARE PROVIDER

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

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e. **Diabetic Emergencies –** Remember, normal blood sugar is about 90 to110.

Hyperglycemia range is anything above 125 to 500+ so there is a broad range for high blood sugar and the person can still function.

Hypoglycemic symptoms occur with most people at about 70 so the sugar level just needs to drop a little for the person to start having symptoms. The brain is more sensitive to a drop in blood sugar and will lose function if the sugar level is too low.

Therefore, low blood sugars are much more of a danger than high blood sugars. If the person starts to exhibit symptoms of low blood sugar, give the person ½ glass of orange juice or regular soda followed by a high protein snack such as milk and crackers or half a meat sandwich. **If you think the person may not be able to swallow, DO NOT GIVE FLUIDS!** Instead put a concentrated sweet such as sugar or frosting inside the mouth.

If you give sugar and the person's symptoms do not go away, you know that something else (such as a stroke) could be causing the symptoms. It will **not hurt** the person to be given the extra sugar if low blood sugar is not the cause of the symptoms (high blood sugar has a larger range of sugar levels).

Also, **INSULIN AND FOOD MUST GO TOGETHER**. If the person has their shot and no food you are asking for a diabetic emergency!!!

7. Urinary System

a. **Urinary tract infections (UTI)** -- usually refers to a bladder infection

Symptoms:
- Decreased mental acuity (more common symptom in the elderly)
- Urine cloudy and foul smelling
- Low grade fever
- Burning sensation during urination

Prevent UTIs with increased fluid intake

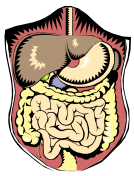
b. **Benign prostatic hyperplasia (BPH)** – an enlarged prostate gland

The prostate enlarges as a man ages. Most of the time this enlargement is benign (non-cancerous) but it can become cancerous. Cancer of the prostate is the second leading cause of cancer-related deaths in men (lung cancer is first). Therefore, it is very important that men have prostate exams especially if symptoms are noted.

Symptoms:
- Difficulty starting and keeping urine flowing
- Dribbling of urine
- Needing to urinate frequently, more bothersome at night
- History of UTIs due to retained urine

Treatment for an enlarged prostate gland may include a TURP (transurethral resection of the prostate) in which pieces of the prostate are removed surgically. Post-op care will include pushing fluids and monitoring for increased bleeding into the urine.

8. Stomach and colon



a. **Ulcers**

- Can be in stomach or in parts of colon
- May cause heartburn
- Bleeding ulcers were thought to be caused by an increase in gastric acid. Now have discovered that a bacteria in the stomach can create a crater in the mucosa lining causing internal bleeding
- Do not take aspirin or NSAIDS (e.g., Ibuprofen)
- Take medication as prescribed

b. **Constipation/impaction/obstruction**—(the longer feces stay in the colon the more water is absorbed and the harder the stool becomes)

- Constipation
  - ✓ A hard stool that is difficult to pass. This is not related to frequency ("I'm constipated because I didn't have a bowel movement yesterday.")
  - ✓ Causes include low fiber diet, ignoring urge to pass a stool, decreased fluid intake, inactivity, certain drugs, aging, and certain medical conditions
  - ✓ Discourage use of routine laxatives-- glycerin suppositories and/or stool softeners preferred

- Impaction/obstruction
  - ✓ Hard, dried feces that are packed into lower intestines (constipation that has gotten worse)
  - ✓ Symptoms are loss of appetite, abdominal cramping, leaking diarrhea, change in behavior
  - ✓ Impaction can lead to complete bowel obstruction
  - ✓ Seek medical attention, usually for oil retention enema, possible manual extraction, and even surgery with severe cases of obstruction

- Diarrhea
  - ✓ Loose, watery stool
  - ✓ Causes include infections, irritating foods, parasites, etc.
  - ✓ **Need to replace fluids to prevent dehydration**
  - ✓ Notify supervisor if consumer has more than two diarrhea episodes in a day

9. Immune system

Immune system is responsible for fighting diseases and foreign bodies. An immune system deficiency can leave the body open to infection. Causes include:

a. Normal aging reduces immune system's efficiency
b. Chemotherapy
c. Steroid treatments (e.g., Prednisone)
d. Recent transplant surgery (medications are prescribed to reduce resistance to foreign body)
e. HIV/AIDS

The number of older people with HIV/AIDS is on the rise. About 10% of all people diagnosed with AIDS in the United States, some 75,000 Americans are age 50 and older.

Therefore, it is important to remember to use Standard Precautions/ Infection Control measures while on the job.

It is also important that you do not pass an infection to people with a compromised immune system as this may lead to an infection they cannot fight.

AGING AND PHYSICAL DISABILITIES MODULE

SECTION IV - PSYCHOLOGICAL AND COGNITIVE CONDITIONS

A. Anxiety

Anxiety disorders include:

Panic disorder	Obsessive-compulsive disorder (OCD)
Post-traumatic stress disorder (PTSD)	Social phobia (or social anxiety disorder)
Specific phobias	Generalized anxiety disorder (GAD)

1. Signs and symptoms

Each anxiety disorder has different symptoms, but all the symptoms involve excessive, irrational fear and dread.

2. Behavioral issues

People with anxiety disorders may not be able to cope with the stresses of everyday life and have difficulty functioning. For example they may not want to venture outside of their homes or they may be afraid of germs to the point of having to wash their hands many times a day. Some people with anxiety disorders can become agitated and aggressive if taken out of their comfort zones. This is especially true for a person with dementia who has an anxiety disorder.

3. Communication techniques

Along with other therapeutic communication techniques you need to use a calm, reassuring approach. Listen with empathy (e.g., “I understand you are upset but you will be safe here.”).

4. Treatment/Management

Treatment is aimed at the cause. If the person has a phobia, treatment may be focused on exposing the person to the thing that causes the phobia gradually (desensitization). Counseling may also help the person cope with stressors to reduce anxiety. Medications, including anti-anxiety agents, may also help. However, most anti-anxiety medications can be addictive and may have undesirable side effects especially in the elderly.

B. Depression

Major depression is the **leading cause of disability** in the U.S. and worldwide.

Older Americans are disproportionately likely to die by suicide. Among the highest rates (when categorized by gender and race) were white men age 85 and older: 59 deaths per 100,000 persons in 2000, more than five times the national U.S. rate of 10.6 per 100,000.

1. **Signs and symptoms**

   a. Persistent sad, anxious, or "empty" mood
   b. Feelings of guilt, hopelessness, worthlessness, pessimism (e.g., “I don't know if I can go on.”)
   c. Loss of interest or pleasure in hobbies and activities that were once enjoyed

   Some symptoms may be side effects of medication the older person is taking for a physical problem. They may also be caused by another condition or illness the person has such as heart disease, stroke, diabetes, cancer, and Parkinson’s disease

   Depression is <u>NOT</u> a normal part of aging

2. **Behavioral issues** (related to symptoms)

   a. Statements about death and suicide
   b. Reading material about death and suicide
   c. Increased alcohol or prescription drug use
   d. Failure to take care of self or follow medical orders
   e. Stockpiling medications
   f. Sudden interest in firearms
   g. Social withdrawal or elaborate good-byes
   h. Rush to complete or revise a will
   i. Overt suicide threats

3. **Communication techniques**

   Be supportive. It is important to let the person know that you are there to listen and spend time together doing things you both enjoy.

   Be concrete and direct, though kind. For example, you could say something like, "You don’t seem to be yourself these days. I’ve noticed that you have been sleeping more and not reading the paper like you used to enjoy doing. Are you OK?" You may find that the person will become defensive, tearful, or angry. However, it is important to keep in mind that your concern could be very helpful, even if it takes the person some time to come around. If you get a reaction like this, follow up at a later time. You might say, "I’m sorry you found what I asked you to be upsetting. I just wanted to help. Please let me know if I can help in any way."

   Avoid being overly light-hearted or confrontational. Many people make the mistake of trying to get a depressed person to "snap out of it." Some do this by cracking lots of jokes and making light of the person’s feelings. Other people will try to "get tough" with the depressed person, saying things like, "You don’t have anything to be upset about," or "Think of all the people who are worse off than you." Such approaches are rarely helpful and may even backfire. The depressed person is likely to feel worse and may even become angry.

   Ask questions. Depressed people often feel very alone and isolated. You might say, "I hope you won’t find my questions rude..." or "Please let me know if I am asking something too personal..." Then ask! Providing the opportunity to talk can be a valuable gesture in helping a depressed person.

Ask about suicidal thoughts. Asking someone if he or she has thought about suicide will NOT increase the likelihood of the person doing so. In fact, people are often relieved to be able to talk about such scary thoughts. One way to do this is to paraphrase something that the person has just said, followed by a question about suicide. For example, you could say something like, "When you say that you feel like giving up on life, do you mean that you have been considering suicide?"

Try to get some help. Call your supervisor and report the situation so that an appropriate referral can be made. If the person is having suicidal thoughts, DO NOT LEAVE THE PERSON ALONE.

Treatment/Management:

Research has shown that certain types of short-term psychotherapy are effective treatments for late-life depression. Combining psychotherapy with antidepressant medication, however, appears to provide maximum benefit. In one study, approximately 80 percent of older adults with depression recovered with combination treatment. The combination treatment was also found to be more effective than either treatment alone in reducing recurrences of depression.

Information adapted from the National Institute of Mental Health's Website: http://www.nimh.nih.gov/

AGING AND PHYSICAL DISABILITIES MODULE

SECTION V - PHYSICAL DISABILITIES

A. Therapeutic interventions

Depending on the person with a physical disability, therapeutic interventions will be unique depending on each individual. Therapeutic interventions can include range of motion (ROM), durable medical equipment (DME), Physical therapy (PT), occupational therapy (OT), speech therapy (ST), proper diet, etc. These interventions can be crucial to maintain or improve the health and welfare of a person with a physical disability.

B. Differences

As with any condition an individual with a disability is unique with unique strengths and challenges. Therefore it is imperative to check with the health care team to determine the interventions that are to be used with each person. For example, a person with multiple sclerosis may or may not be incontinent.

C. Spinal Cord Injuries (SCI)

The spinal cord is a long, rope-like cord about the width of your little finger that extends from the brain to the lower back where it fans out like a horse's tail; it is protected by bones called vertebrae. In between the vertebrae are discs which act as cushions. The spinal cord is the second most protected organ in your body, next to the brain.

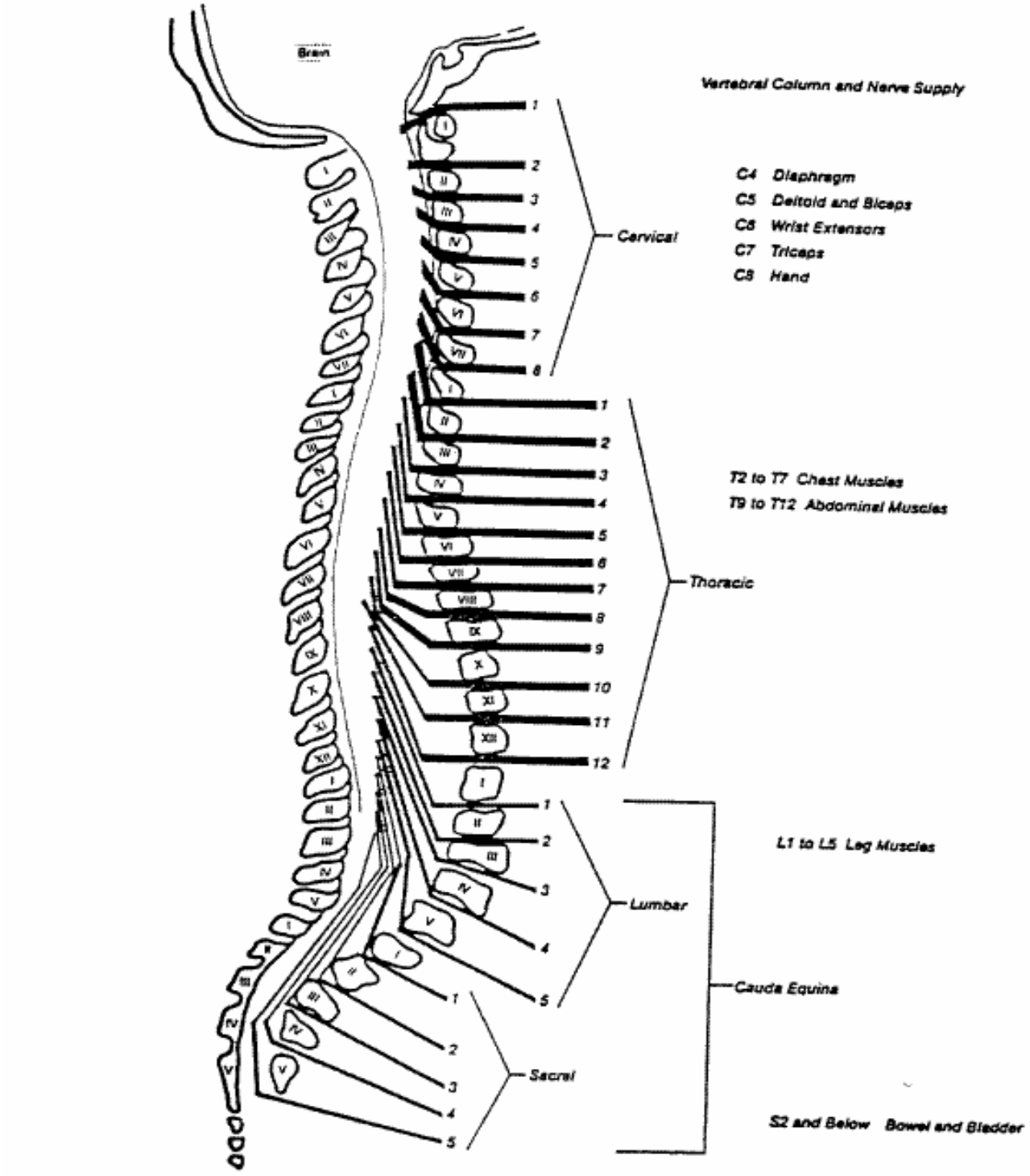
The spinal cord can be damaged easily. Some spinal cord injuries (SCI) are the result of something going into the spine, for example, a gunshot wound. Another type of injury can be something that causes pressure within the spinal column. An example would be a tumor inside the spinal column. Another type of injury can occur from actually breaking the vertebrae, which can then sever the cord.

Types of Injuries

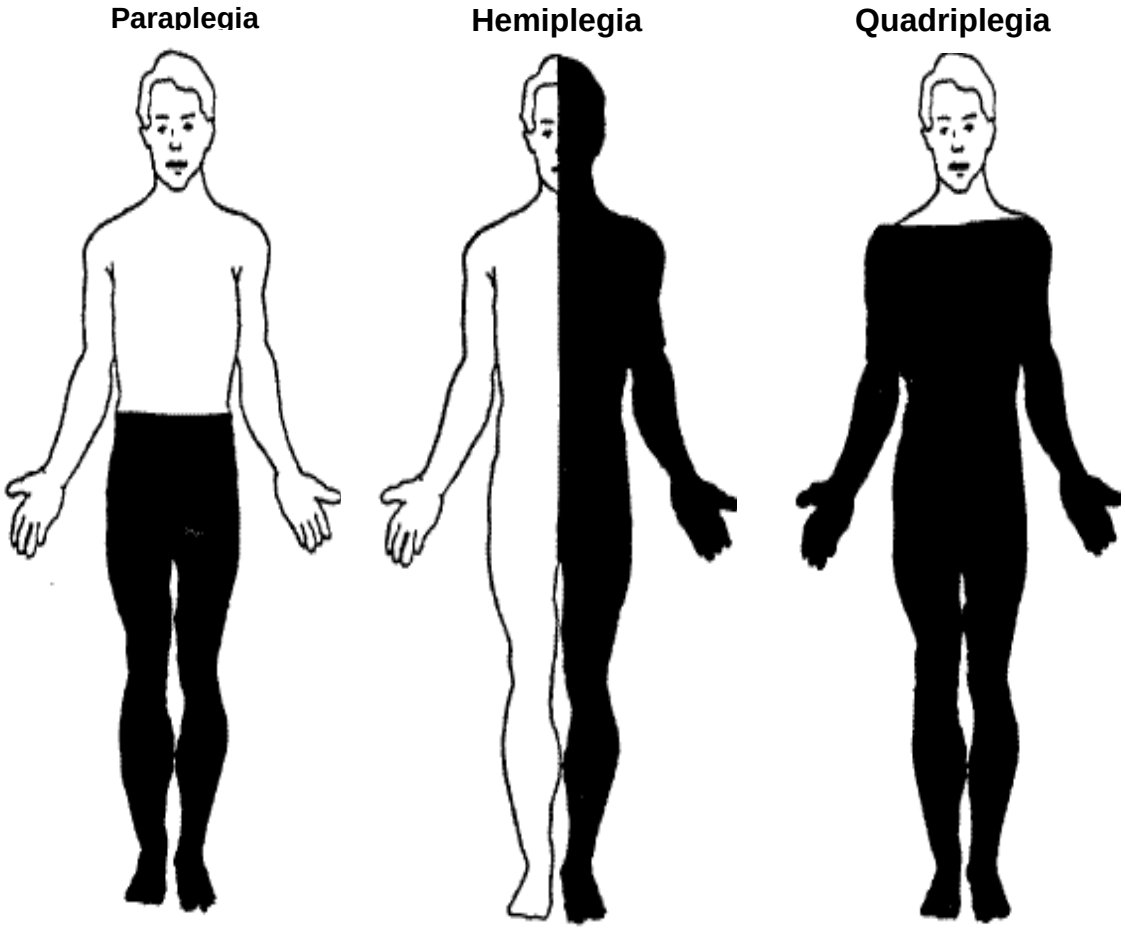
Complete – All the nerves at the level of injury are damaged. There will be no voluntary movement or sensation below the level of injury.

Incomplete – Partial damage to the nerves at the level of injury. There may be some movement and/or sensation.

THE VERTEBRAL COLUMN



Types of Plegias -



This diagram illustrates the types of “plegias” and the areas of the human body that must be paralyzed in order to fit into a specific category of plegia (Tetraplegia = three limbs affected).

1. **Autonomic Dysreflexia (Hyperreflexia):**

   Autonomic Dysreflexia (AD) is an emergency medical condition that causes extremely high blood pressure as a result of a stimulus below the level of injury**. This can lead to a stroke!!** It generally occurs in individuals who have an injury at T-6 or above.

   What happens?

   When a stimulus occurs in the non-injured body, blood vessels dilate and the blood pressure rises. Messages are sent from the brain to lower the blood pressure to keep the body in homeostasis (even state). In a person with a SCI, those messages cannot pass through the level of injury and the blood pressure rises uncontrollably. This rise in blood pressure will cause signs and symptoms that something is wrong.

Symptoms to look for are:

a. Pounding headache
b. Profuse sweating (above the level of injury)
c. Nasal congestion and pupil constriction
d. Goose bumps/chills
e. Slow heart rate (brain's response to high BP)
f. Vision changes (seeing spots, blurry vision)
g. Anxiety, apprehension
h. Flushing of skin (above level of injury)

What to do:

a. Have the person immediately sit up or raise head to 90 degrees. This will reduce the BP.
b. Determine the cause.
c. If you can't determine the cause, GET HELP!! Call or go to the hospital. Be aware that not all health providers will be familiar with AD. It is a good idea to carry an ID card, which explains it.

Causes

Causes of AD are varied. Basically it is any stimulus below the level of injury. The following are some of the causes:

a. Full, distended or infected bladder (Check the catheter tubing for blockage)
b. Blocked bowels
c. Pressure ulcers
d. Broken bones, severe cuts
e. Labor pains, menstrual cramps
f. Extreme temperatures, sunburns
g. Tight clothes
h. Stress
i. Ingrown toenail

*This is not an exhaustive list. As stated earlier, it is basically any stimulus below the level of injury.

CARRY A CARD!

Below is an example of a card a person can cut out and carry in a wallet. Put the person's name in the space below "FOR AUTONOMIC DYSREFLEXIA." Let health care team members and contact persons know this person has this card and use it with medical staff for instructions in emergency care.

It may save the person's life!

MEDICAL ALERT FOR AUTONOMIC DYSREFLEXIA

Name:_____

Is subject to the above syndrome. This is a serious medical problem that can occur in people with a spinal cord injury above the 6th thoracic level. The symptom of autonomic dysreflexia (AD) can be caused by many types of stimuli below the level of the spinal cord injury, but the most common emergency causes are: (1) full or spastic bladder or (2) bowel distention (usually from stool in the rectum). Severe AD is a medical emergency which if not properly treated can result in cerebral vascular hemorrhage (stroke).

Symptoms:

1. Pounding headache
2. Flushing of skin and sweating above the level of injury
3. Increased blood pressure (as high as 250/150), slow pulse
4. Apprehension/anxiety
5. Vision changes-blurring, spots before the eyes
6. "Goose bumps"

What To Do: (First Aid) (Most of these measures are for emergency personnel)

1. Place patient in a sitting position
2. Drain the bladder.
   (a) If catheter is in place, check for kinking. If catheter is plugged, do not try to irrigate. Change foley using Lidocaine jelly for lubrication.
   (b) If no catheter is present, insert a catheter using Lidocaine jelly for lubrication. Do not crede (push on) the bladder.
3. If emptying the bladder has not decreased the blood pressure and there is stool in the rectum, apply Lidocaine jelly to the anal sphincter and wait three minutes. Then, using a Lidocaine-lubricated gloved finger, gently remove stool from the rectum.

Medical Treatment:

1. If the AD episode is not resolving after the above measures, medical treatment is necessary. Ask the patient if he has his own supply of any of the AD medications. If not, transport patient to an emergency room as soon as possible.
2. If the AD episode is not resolving and/or the blood pressure reaches 160 systolic, give the patient Nifedipine 10 mg sublingual. Instruct patient to bite through the capsule and hold it beneath his tongue. May repeat Nifedipine dosage after 15 minutes if blood pressure has not responded.
3. Continue to look for causes of AD by checking the patient's entire body. Other causes include fractures, sores and tight clothing.
4. Alternative treatments (if Nifedipine is not available or does not work):
   (a) Nitroglycerine ointment: 1 inch to upper chest or back. If no resolution in 15 minutes add additional 1 inch.
   (b) Markedly elevated blood pressure not responding to the above measures should be treated with IV Apresoline (20 mg/1cc). Inject .5c SLOWLY. May repeat dosage after 15 seconds of no response.
5. Blood pressure may be safely lowered to 90/60, which is typical of quadriplegics in the sitting position.
6. **After an episode of AD, it is not uncommon for a second episode or rebound to occur, so blood pressure should be checked every 30-60 minutes for the next 4-5 hours.**

Psychological Adjustment

A person who has had a SCI will go through a physical adjustment and a psychological adjustment. There is no set time for the length of this process; nor is there a specific pattern as to how the person will handle it. Often you will see the individual experience the phases of the Grieving Process. Your role as the assistant is a vital one. Be as supportive as possible. Be honest with the person. It is good for the individual to look into the future, but remind them to focus on where they are now, both physically and emotionally.

Remember, an individual with a SCI still has talents and abilities to offer. Using adaptive equipment, modifying the environment, etc., will assist individuals with a SCI to utilize the abilities they have. To have your body's physical ability change often creates the idea that you no longer have anything to offer. It's all a process of learning how to express yourself again.

2. Bowel care and bladder management

The goal for a bowel care program is to establish emptying the bowel at regular times, and prevent embarrassing accidental bowel movements. A bowel care program usually consists of inserting a suppository followed by digital stimulation "Dillie" routine. A bowel care program is usually established three times a week, but does vary from consumer to consumer.

Please be aware — at most agencies DCWs are not allowed to insert a suppository or perform digital stimulation. However, check with your supervisor to determine your job responsibilities. DCWs can perform the clean-up after a qualified person does the suppository and stimulation.

Bladder Control –

a. Intermittent --catheter inserted every 2-4 hours directly into the bladder through the urethra allowing the bladder to drain.
b. Indwelling – catheter inserted into the bladder through the urethra and remains inside the bladder.
c. Supra pubic catheter--Catheter is inserted just above the pubic bone through the abdomen into the bladder.
d. External catheter – (also known as a condom, Texas, or buffalo catheter)
    - Change every day (Easier to change if penis is somewhat erect)
    - Wash skin well to remove glue and old urine
    - Dry skin thoroughly
    - Clip hair that may be caught in glue or catheter

D. Multiple Sclerosis (MS)

Multiple Sclerosis is the most common central nervous system disease among young adults in the United States. The central nervous system acts like a switchboard, sending electrical messages along the nerves to various parts of the body. These messages control all our conscious and unconscious movements. Most healthy nerve fibers are insulated by a MYELIN SHEATH, a fatty substance that aids the flow of messages. In MS, the myelin breaks down and is replaced by sclera (scar tissue- sclerosed). This distorts or even blocks the flow of messages for vision, walking, talking, etc. Multiple Sclerosis is not a mental illness, contagious, preventable or curable.

What causes Multiple Sclerosis?

- Virus attack - MS might be caused by some slow-acting viruses, or might be a delayed reaction to a common virus.
- Immune reaction – MS might involve an auto-immune reaction in which the body attacks its own tissues by mistake.
- Combination – when viruses invade the body, they take over body cells. The body's defense system might become confused because some viruses take over parts of cells and it might attack both host cells and virus cells.

Who gets Multiple Sclerosis?

Since there is so much we don't know about MS, we can't predict who might experience it. However, there is a pattern in who is more likely to develop it:

- Young adults – symptoms usually appear between ages 20 and 40
- Women – slightly more women than men develop MS
- People in areas with high standards of sanitation. Perhaps children in these areas are not exposed to some factor that would help build immunity to MS

What are the symptoms of Multiple Sclerosis?

- Seeing double or uncontrolled eye movements
- Partial or complete paralysis in any part of the body
- Shaking of hands
- Loss of bladder or bowel control
- Staggering or loss of balance
- Speech problems such as slurring
- Weakness or unusual tiredness
- Loss of coordination
- Numbness or prickly feelings
- Obvious dragging of feet

1. Exacerbation

This term is quite often associated with MS, meaning the consumer is having a flare-up. Relapsing-remitting multiple sclerosis is a form of MS in which symptoms randomly flare up (relapse) and then improve or fade. This relapsing-remitting pattern emerges with the onset of the disease and may last for many years.

2. **Progressive**

The disease is progressive from the start, although damage to the central nervous system occurs at different rates in different people.

For more information contact: National Multiple Sclerosis Society, Arizona Chapter (480) 968-2488

E. Amyotrophic Lateral Sclerosis (ALS) (also known as Lou Geherig's disease)

This disease is a progressive wasting away of certain nerve cells of the brain and spinal column called motor neurons. The motor neurons control the voluntary muscles, which are the muscles that allow movement. The cause for ALS is unknown. Symptoms of ALS in the beginning are weakness of one leg, one hand, the face, or the tongue.

ALS is a progressive, disabling disease. ALS affects walking, speaking, eating, swallowing, breathing, and other basic functions. These problems can lead to injury, illness (e.g., pneumonia), and other complications. A person diagnosed with ALS will need to make decisions on treatment or lack of treatment as the ALS progresses. Treatment in the early stages can include the use of a cane, shower chair, physical therapy, occupational therapy, speech therapy, and medication. As the disease progresses assistance to breathe via a ventilator and tube feeding will be necessary.

F. Muscular Dystrophy (MD)

Muscular Dystrophy is an inherited disease. It is caused by a defect in genes that are important for healthy skeletal muscles causing them to become progressively weaker. Symptoms gradually get more severe as muscles get weaker There is no cure and no way to arrest the disease process. Muscular Dystrophy (MD) is not contagious.

1. **Duchenne -** Develops early, between 2 – 6 years of age. Symptoms include: waddling or walking on toes, difficulty in running, protruding abdomen. Sex-linked: 50% more likely to occur in males.

2. **Facioscapulohumeral** - Usually becomes evident in teens but may appear in infancy, childhood or middle age. Facial weakness is always present (difficulty closing eyes and whistling, unlined face even in middle age). Other symptoms include difficulty raising arms, lifting objects, prominent shoulder blades. Caused by a dominant gene that appears in nearly every generation and affects both sexes.

3. **Limb-girdle** - Usually becomes obvious in late childhood or early adolescence. Symptoms vary with body part affected: difficulty raising arms and lifting objects, drooping shoulder, waddling, frequent falls, difficulty rising from floor and climbing stairs. Caused by a recessive gene that appears only if both parents carry the gene; affects both sexes.

4. **Myotonic** - Appears in early adulthood, less often in adolescence. Symptoms include: stiffness in hands and feet, especially after chill, difficulty relaxing grip, and facial weakness. Caused by a dominant gene that affects both sexes.

AGING AND PHYSICAL DISABILITIES MODULE

SECTION VI - SEXUALITY ISSUES

VI. Sexuality Issues

One's sexuality involves the total sense of self as male or female, man or woman, as well as perceptions of what it is for others to be female or male. It includes attitudes about one's body and others' bodies. It expresses one's definition of gender identity. Sexuality is emotional, physical, cognitive, value-laden, and spiritual.

A distinction should be made at the outset between sex and sexuality. Sex refers to the physical act of making love, to genital expression. "Sex is, in fact, only a small part of sexuality. Sexuality is an integrated, individualized, unique expression of "self."

Sexuality is emotional - With the coming of puberty, boys and girls experience new awareness of their bodies, other persons, and related emotions. Throughout all of life, sexuality deals with one's feeling about self and others, pain and pleasure, distance and closeness, love and hate, physical touching or restraint.

Sexuality is physical - It involves touching, physical closeness, and genital sexual expression. All five senses are involved in one's sexuality; touch, smell, taste, visual and hearing.

Sexuality is cognitive - Mental attitudes, self-understanding, human experiences, and relationships help express who and what persons are as sexual beings. Language is a key part of our sexuality both in naming parts, physical acts and our own experiences in communication with other persons.

Sexuality is value-laden - Words and concepts such as justice, love, norm, should, and should not, are ethical in character and are important to the full understanding of sexuality. One's values determine approaches to honesty, fidelity, promise-keeping, truth-telling, and the purposes of sexual expression.

Sexuality is spiritual - The sexual act involves mutual giving. There is a voluntary surrender of self to another through which a larger unity is achieved without the abridgement of freedom. Elements of commitment, being in touch with another and with oneself are involved in one's sexuality and relationships to others as sexual beings.

Sexuality is personal - Each person is a sexual being on her or his own terms. In that sense, one's sexuality is unique, one of a kind. It is communication that is fun and playful, serious and passionate.

Sexuality is social - It relates to such social policy questions as rape laws, equality of women and men in matters of employment, guidelines for genetic research, and abortion. It affects cultural understandings of socialization as male and female, the role of pornography, and the meanings of marriage and community.

Excerpted from: Human Sexuality, A Preliminary Study, The United Church of Christ

A. Aging

Aging can have an impact on sexuality and sexual functioning. As with other organs the reproductive and sexual organs lose efficiency. Women usually begin to have vaginal

dryness and oftentimes males have difficulty with erectile dysfunction. We don't discuss sexuality enough when considering the lives of older adults. It's easy to assume that aging brings dramatic changes and that sexuality is not a topic that concerns older adults to any great degree. Sometimes, however, events bring about a dramatic shift in awareness and understanding. The boom in Viagra prescriptions is an example of such an event.

(Refer to Aging and Human Sexuality Resource Guide –www.apa.org)

There is much information on the Internet regarding sexuality and aging, sexuality and dementia, sexuality and Alzheimer's disease, etc.

B. Disability

Disability can have an impact on sexuality and sexual functioning. Major types of disabilities and typical sexuality issues for those disabilities are described below. For detailed information about how a disability may affect sexual functioning consult a physician or other resource professionals.

Amputation does not affect sexual organ function unless the amputation involves the bowel or bladder. Amputations do not affect or lower the desire of sexual activity. Loss of a limb may cause depression or lower self-esteem but talking to a counselor, friend, or other professional can help eliminate these problems. Amputation will limit some of the physical activities which may give your partner pleasure but open communication with you partner is the key to removing any stigma surrounding your amputation.

Arthritis does not affect sexual organ function but can impose limitations on physical activity. Pain and stiffness are the biggest factors that can interfere with an active sex life. Pain can dull the desire for sexual activity and limit the positions you can use in sexual acts. Fatigue from dealing with activities of daily living may also decrease your sexual desire. Stiffness can restrict movement and affect use of limbs. Experimentation with positions, the timing of medication and the timing of sexual activity can be worked out so that sexual activity is possible and pleasurable. In addition, the use of heat and warm-up exercises can be helpful.

Like amputation, arthritis can cause depression and lower self-esteem. Medications, too, can affect sexual desire. Other disabilities associated with arthritis can also cause problems for the person who wants to be active.

Counseling may also be appropriate. A positive note on arthritis and sexuality is that many people with arthritis report sexual activity actually relieves pain up to eight hours after intercourse.

Blindness itself does not create any problems with sexual functioning. Rather, some of the disabilities which lead to blindness can cause other problems related to sexual functioning. For example, diabetes can cause blindness and also is known to cause impotence in some men. Congenital blindness will cause a woman to start her cycle earlier and she may have more irregularities. This happens because the pineal gland located in the brain regulates a woman's period and is affected by lack of light.

Cerebral Palsy does not cause loss of sexual functioning or loss of desire for sexual activity. Physical problems such as sensory loss and limited movements due to spasticity

can be a problem. Medication may be helpful. Communication between partners is important when dealing with physical barriers. In many cases, people with cerebral palsy are socialized together and may develop relationships with each other. If this happens, education and counseling of all persons concerned (guardians need to be included if the partners have legal guardians) can be helpful to the two people desiring a sexual relationship. For the individual with cerebral palsy, the biggest obstacle to sexuality with a non-disabled person is the attitudinal barriers imposed by society. These barriers tend to socially isolate the person who has cerebral palsy, thus making communication and sexual activity more difficult.

Deafness creates no problem with sexual functioning. However, since the act of giving and receiving pleasure involves communication, the couple will need to work out a system for expressing needs and desires. One might also consider leaving a light on or using candles to enhance visual communication and to fully appreciate your partner's response.

Diabetes is not always thought of as a disability, yet it is currently the leading cause of permanent physical impairments in the United States today. Between 25 to 49 percent of males with diabetes develop impotence. There has been no correlation between diet, duration of diabetes, or types of medication used for control over disability and the increase of impotence.

There also has been no demonstrated loss of interest in sexual activity among the diabetic population. Regardless of the reasons for the possibility of impotence, the person with diabetes may want to consider a penile prosthetic to increase sexual activity.

Epilepsy is usually thought of as a disorder occurring within the brain which causes some type of altered consciousness and which may be accompanied by uncontrollable physical movements or seizures. Men with temporal lobe epilepsy have experienced impotence and loss of sexual desire but not necessarily at the same time. Some medications used to control epileptic seizures may cause depression or drowsiness which, in-turn, may lower sexual desire; but these drugs do not cause loss of sexual functioning. Sexual activity does not cause seizures.

Activities sometimes associated with sexual activity such as excessive drinking, emotional tension, fatigue or lack of sleep and food may contribute to setting off seizure activity. Careful monitoring of activity, diet and rest should help you keep your epilepsy under control. Like cerebral palsy, epilepsy carries negative social stigmas, which are sometimes the biggest obstacle to enjoying sexual activity. Although major educational campaigns are underway, the person with epilepsy still must take the lead to make potential sexual partners understand that epilepsy does not interfere with sexual functioning, love, or marriage.

Developmental Disabilities do not affect sexual functioning or desires. Most of the problems experienced by people who are developmentally disabled relate to the attitudes of non-disabled members of the general public. In the case of legal guardianship, all persons involved may find it helpful to meet with counselors or other professionals. Education about human sexuality is important for mentally disabled persons and all others concerned with them. Education and communication will be necessary to work things out for both partners.

Head Injury can cause a variety of physical and emotional problems. These problems can be minor or major depending upon how much and what parts of the brain were damaged.

No two head injuries are alike. Physically, there is no impairment in the sexual organs. The problems with sexual function stem from other physical issues such as loss of awareness of where your body is in space, loss of sense of rhythm and timing, loss of movement on one side of the body, or loss of sensation, which can limit sexual pleasure. Communication with the partner is the key to working out these physical issues.

However, if a person who has a head injury also experiences emotional disorders, then, depending upon the severity of these disorders, his or her ability to process information may be limited. The person may show poor judgment, irrational thinking and be very impulsive. The limbic system located in the brain stem is thought to control emotions and sexual urges. So, if the head injury includes damage to the limbic system, emotional problems and uncontrollable sexual urges may result. Education about the disorder can help but frequently, behavior modification programs and counseling are necessary.

Spinal Cord Injury does affect sexual functioning or desires. Since a spinal cord injury (SCI) affects virtually every system of the human body, many people who sustain SCI have serious concerns about how their injuries have affected their ability to participate in and enjoy a sexual relationship. Sexual function in humans is controlled by parts of the central nervous system (CNS), particularly the brain and spinal cord. Interruptions to the CNS through injury to the spinal cord will therefore have some effect on sexual function. The extent to which sexual function is impaired, however, depends on a variety of factors including the level of injury, the severity of damage to the spinal cord, and whether the individual is male or female.

Female Sexual Function After SCI – A female's ability to engage in sexual activity is less likely to be affected by SCI by virtue of the way the female body is constructed. A woman is often able to have intercourse as easily after SCI as before, although additional lubrication may be needed to avoid chafing and to make the act of intercourse easier to initiate. Alternative positioning of one's body may have to be considered as well.

Male Sexual Function After SCI – For males, the situation of sexual functioning is a little more complicated. Some men are able to achieve erections quite easily, while others can achieve erections occasionally and some are unable to achieve erections at all after a SCI.

Sexual Sensation After SCI – As with other basic physiological functions after a SCI, sexual sensations can also be altered. Some of the nerves a person once counted on to provide pleasurable feelings in sexual organs and other erotic areas of the body may no longer be working as they did before injury. Some people retain specific sexual sensations in the genital areas, while others notice they are diminished or absent. However, many others have reported heightened sensations in different parts of the body – the neck, earlobes, arms or other areas of skin.

Many people who have sustained a SCI have indicated that their total enjoyment of the sexual experience after SCI is as good as, if not better than, their pre-injury sexual experiences. Necessity in many cases encourages them to concentrate on "holistic" sexual experiences rather that on genital-specific sex. Many individuals report that they can still achieve climax but not in the same way as before their injury. Again, the best way to discover personal likes, dislikes, and needs is exploring openly with a willing and loving partner.

SCI and sexuality was adapted from: SCI Network Fact Sheet 4, "Sexuality After SCI"
http://spinalcordinjury.net/docs/scifact4.html

AGING AND PHYSICAL DISABILITIES MODULE

SECTION VII - DEMENTIA SPECIFIC CARE

This part of the training is intended to introduce the student to Dementia-specific care. It is intended to be an overview of the topic.

However, the Alzheimer's Association, Desert Southwest Chapter, has developed a module by a committee of professionals in the field of dementia-related care that will provide in-depth training on providing care and treatment options.

Anyone who provides care for individuals with cognitive impairments and dementia is encouraged to attend the Cognitive Impairment/Dementia module training.

A. Overview

What is Dementia?

a. Group of symptoms which may accompany certain diseases or conditions
b. Progressive, cognitive (thinking, reasoning, remembering) decline significant enough to impair daily activities

What are the Symptoms?

a. Decline in memory, thinking, and reasoning
b. Changes in personality, mood, and behavior
c. Difficulties in language, visual recognition, and executing activities

1. Types of Dementia

a. Reversible (Can be reversed with appropriate medical care)
   - Medical conditions
     - ✓ Dehydration
     - ✓ Infections
   - *Chronic condition being out of control (e.g., thyroid problems)*
   - Reaction to medication
     - ✓ Overmedication, mismanagement, withdrawal
   - Psychiatric causes
     - ✓ Depression, lack of sleep, stress

b. Irreversible (Cannot be reversed with appropriate medical care)
   - Alzheimer's Disease – Most common form
   - Vascular (Multi-infarct) Dementia – Caused by strokes
   - Lewy Body Dementia – Fluctuations in memory, hallucinations(Anti psychotics may make condition worse), rigidity in movements
   - Parkinson's Disease
   - Pick's Disease - Frontotemporal dementia—behavior changes, aggressiveness
   - Huntington's Disease
   - AIDS
   - Others such as Creutzfeldt-Jakob Disease

Alzheimer's Disease: Scope of the Problem

a. Nerve fibers twist into a tangle not allowing conduction of impulses
b. Cause still being researched
c. Affects more women than men
   - 10% of people 65-74
   - 19% of people 75-84
   - 47% of people >85
d. Average life expectancy after diagnosis is 10 - 12 years
e. 7 out of 10 persons with dementia live at home
f. 80% of caregivers suffer from high levels of stress; 50% suffer from depression
   Caregiver stress is a major reason why service is requested

2. Stages of Alzheimer's Disease

Early Stage
- Short term memory loss
- Difficulty handling checkbook, finances, organization
- Poor judgment and personality changes

Mid-Stage
- Memory worsens
- Increased difficulty expressing oneself
- Difficulty using objects correctly (e.g., toothbrush, silverware)
- Disorientation to time and place
- Restlessness or pacing
- Behavior changes; Loss of impulse control
- Self-care abilities more impaired

Late Stage
- Limited/nonsense/no speech
- Oriented only to self
- Incontinent bladder and bowel
- Needs maximum assistance walking/unable to walk/bedridden
- Requires total assistance for all ADLs

Terminal Stage
- Late stage criteria PLUS
  - ✓ Difficulty chewing/swallowing
  - ✓ Infection/recurrent fever in past 12 months
  - ✓ Pressure ulcers
  - ✓ Weight loss, weight loss, weight loss

B. Communication strategies

Also refer to **Communication** section in Core Training for verbal and non-verbal strategies

The two most important factors in working with the individual with dementia are <u>your actions and reactions</u> to the individual and his/her behavior.

<u>Tips for Working with Difficult Behaviors Associated with Dementia</u>

1. **Keep calm**. If the person is excited and you become excited, the situation will only get worse. Instead, maintain a calm voice and stature. Talk soothingly and reassuringly, using short, simple sentences.
2. **Take the person away from the present environment (<u>diversion</u>).** Perhaps there is something or someone causing the agitation. Try a different scene, such as a backyard patio, to see if the agitation decreases.
3. **Talk and move slowly so that the person does not feel threatened**. If the person is already feeling insecure or frightened, it will not help if someone else rushes in or speaks in a loud voice. Instead, stay relaxed and try not to upset the person further.
4. **Try soothing touch.** For certain people, a gentle arm around the shoulders, holding hands, or a gentle back scratch can be reassuring and soothing.
5. **Do not try to argue with the person**. Logical reasoning may seem like a good approach, but, because of the brain damage, it will not help a person with Dementia. Instead, try to "go with the flow" and let the person say whatever she/he wants to, even if you know it is not true.
6. **Respond to the emotions of the person**. Regardless of what caused the agitation, the person is upset. When talking with him/her, try to focus on what the person is feeling or what emotions they are displaying, instead of the actual words they are using.
7. **Try to <u>redirect</u> the person**. Changing the subject or the environment can often be helpful. Begin to talk soothingly about something you know the person enjoys, such as their family, or introduce an activity the person likes to do, such as draw pictures.
8. **Always treat the person with respect and dignity.** Never forget that the person is an adult, despite the behavior they are exhibiting. Again, recognize that it is the disease causing the behavior, not the person. **Don't punish them or talk to them like a child.**

These tips are adapted from "Alzheimer's Disease: Pieces of the Puzzle" produced by Arizona Long term Care Gerontology Center (now the Arizona Center on Aging) at the University of Arizona.

Also utilize the "Life Story":

The "Life Story" lists some of the unique aspects of that person's life. It can give caregivers valuable cues for:

- **What to talk about when trying to use distraction**
- **Activities to engage the consumer in**
- **Music that the person would enjoy.**

If able, have the person help you complete a life story as part of reminiscing, or ask the family to assist in completing a "Life Story".

C. Difficult behaviors

1. Causes

a. Effects of Alzheimer's Disease on the brain
b. Confusion
c. Fatigue
d. Pain
e. Boredom
f. Lack of routine
g. Under/over stimulation
h. **The caregiver's approach and reaction to the behavior**

2. Types

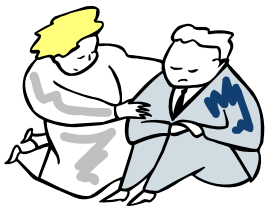
a. Combativeness and aggression
b. Wandering and rummaging
c. Physical restlessness (pacing)
d. "Sundowning" (becoming more confused/agitated in the late afternoon and evening)
e. Inappropriate sexual behavior

3. Tips

> The approach used by a caregiver can significantly impact problem behaviors with a person with dementia. A caregiver can escalate a problem or they can calm the person by using the correct approach.

a. Introduce yourself at each encounter
b. Use touch as appropriate
c. Try to determine the cause of the behavior (boredom, pain, anxiety, etc) and then try to reduce/eliminate the cause
   - Boredom -- try a functionally specific activity
   - Pain -- try the appropriate non-pharmacological treatment first
   - Anxiety -- try reassurance and diversion

d. Use the "Soft Approach"



   - Smile
   - Warm demeanor
   - Pleasant voice tones
   - Go slow
   - Talk in short, simple sentences
   - Avoid correcting/confrontation
   - Appeal to the emotion and let the person know you will keep him/her safe
   - Be flexible in getting tasks accomplished

4. Other

AD and sexuality --the following changes in sexual behavior, if exhibited, can be very upsetting for family members and the DCW:

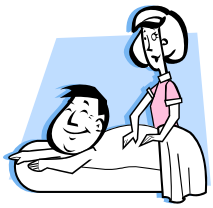
a. Bold behavior – the person may forget marital status and begin to flirt with others including the DCW
b. Unreasonable jealousy or paranoia
c. Exposing or fondling self inappropriately
d. Misinterpretations – making sexual advances to another person (including the DCW) because he/she believes the person is the spouse

The DCW should try to determine if there is a cause for the behavior. If the person is fondling him/herself, the person may need to use the bathroom. If the cause cannot be corrected, gentle diversion usually works. However, if the DCW feels threatened or needs advice, the DCW should call his/her supervisor.

D. Activities of daily living

1. Personal hygiene

a. Bathing



Frequent Behaviors Seen During Bathing

- Fighting/resisting the caregiver
- Yelling/swearing/biting
- Crying/moaning

Why Behavior(s) Occur

- Person may be experiencing discomfort and/or loss of dignity
- The person is trying to say “NO”!

Caregivers need to re-think the bathing situation and see the behaviors as “self-protective” rather than “combative” or “resistant”

Steps to Successful Bathing: **Re-think the Bathing Experience**

- Ask the family about the person’s bathing preference prior to dementia
  - ✓ Shower vs. bath
  - ✓ Frequency and time of day
- Use bathing preferences and rituals that have been pre-established
- Keep in mind the goal is to create a comfortable and pleasurable experience for the person with dementia

Steps to Successful Bathing: **Approach Strategies**

- Always use the "soft approach"
- Don't ask the person if she wants a bath/shower if you are not willing to accept "no" for an answer!
- If the person refuses you, leave and come back again in a few minutes
- Use a variety of approach techniques
- Focus on getting "freshened up" or on a reason for the person to get clean

Bathing Steps: **Be Organized!**

- Have the room ready to go!
  - ✓ Shower room should be warm, well lit, with all the supplies ready to go
  - ✓ Position the person comfortably
  - ✓ Have enough bath blankets/towels to keep the person covered at all times

Bathing Steps: **Helpful Tips**

- Remember to keep the person covered at all times
  - ✓ Lift the blanket/towel as you bathe the person and then replace
- Begin bathing the least sensitive area first, the feet!
  - ✓ Begin with the feet/legs and move up from there, saving the perineal area and face until last
- Utilize distraction techniques
  - ✓ Play music or sing (person's preference—use the person's "Life Story")
  - ✓ Give the person something to hold
  - ✓ Give the person something to eat or drink
  - ✓ Give the person a piece of chocolate while washing the perineal area

b. **Shampooing**

- Save washing the hair until last OR separate it from the bath completely
  - ✓ Consider shampooing hair in a chair using washcloths and no-rinse soap
  - ✓ Make an appointment at the beauty shop/barber

Information adapted from: Palliative Care for Advanced Dementia; Train the Trainer Program
Alzheimer's Association; Desert Southwest Chapter

E. Planning Activities

1. **Importance**

   Activities geared to the functional abilities of the person provide an opportunity for social interaction, encourages creative self-expression, increases feelings of achievement and enjoyment, and decreases agitation, boredom, and isolation.

2. **Functionally specific** gear activities to the functional abilities of the person. If the activity is too difficult, the person may become overwhelmed; if too easy, the person may become bored. Both can lead to problem behavior.

   Possible activities:
   - Give the person something meaningful to do such as folding towels
   - Look at picture books and magazines and make a card or cut out pictures
   - Play music of the person's preference or try singing old favorites
   - TV programs only if the person shows interest (e.g. nature programs, musicals and "Lawrence Welk", old comedies like "I Love Lucy")
   - Offer frequent snacks (sweets) and fluids
   - Use lotion to give a 1-2 minute hand/foot massage – consider adding an essential oil for aromatherapy
   - Read a poem, prayer, or scripture verse

3. **Exercise**

   - Accompany the restless person on a walk even if just looking at flowers on the patio
   - Designate a safe area where the person can walk
   - Take a person who uses a wheelchair for a walk

F. Pain Management Techniques

A person with Dementia may not be able to tell a caregiver that he/she is in pain. Therefore, it is imperative that the caregiver be alert to changes in the person's behavior (even be the cause of problem behaviors) that might signal the person is in pain. Try to provide one of the following non-pharmacological approaches first:

1. **Non-pharmacological**
   (not involving medication - caregiver can do these measures without a physician's order)

   a. Positioning/repositioning/walking
   b. Toileting
   c. Offer snacks/fluids
   d. Give a lotion massage
   e. Quiet time/reduce stimulation in environment
   f. Listen to music
   g. Adjust body temp (person may be too hot or too cold so adjust clothing/thermostat)
   h. Use soothing touch and tone of voice

2. **Pharmacological**

If the non-pharmacological strategies do not work, report this to the family and your supervisor. The person's physician may be able to prescribe a medication that will be helpful. Just keep in mind that:

a. A non-aspirin pain reliever such as Tylenol usually works well.
b. Narcotics are usually not tolerated well in elderly individuals.
c. Anxiety in an elderly person with Dementia is not always well-managed by anti-anxiety agents. Pills don't always work and some have serious side effects.

Adapted from: Palliative Care for Advanced Dementia; Train the Trainer Program
Alzheimer's Association; Desert Southwest Chapter

G. Safety Concerns

Safety is the primary responsibility when caring for a person with Dementia. Make sure the usual fall-prevention measures are used (e.g., clear pathways, no scatter rugs, etc.). Refer to the accident prevention section of the Core Training.

Also, if the person with Dementia wanders, refer to the Safe Return® program through the local Alzheimer's Association Chapter. Once enrolled, if the person becomes lost, one call immediately activates a community support network to help reunite the lost person with his or her caregiver.

What would you do in these situations? What would you document and report?

A. You have been assigned to give a bath to Hazel who has Alzheimer's disease. Hazel is sitting at the kitchen table, drinking a cup of coffee. You say to Hazel, "Hazel, I am here to give you a shower. Why don't you finish your cup of coffee and I will start getting everything ready for you." Hazel says, "No, I just took a shower this morning and I don't need a shower."

What would you say and do? What would you document and report?

B. You are providing respite care from Noon until 6PM with Jean who has Alzheimer's disease. Jean's husband died last year and Jean came to live with her daughter. About 4PM Jean starts pacing and you find her at the locked front door trying to open it. When you ask Jean what is wrong, Jean states that she must go home now so that she can cook dinner for her husband. Jean is getting increasingly agitated.

What would you say and do? What would you document and report?

C. You are working with Ben who is in the late stages of Parkinson's disease and has Dementia. Ben requires a mechanical lift to get out of bed. You are midway through an eight-hour daytime shift.

What is an appropriate activity you can do with Ben?

D. You have been providing housekeeping and personal care assistance for Sarah who is 89 years old with severe arthritis. You notice that Sarah is pacing more, seems more agitated in the past few weeks, and is having problems with overdue notices on her utilities.

What action(s) would you take? What would you document and report?